U.S. Department of Labor

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Issue date: 22Feb2002

In the Matter of	:	
	:	
JAMES F. GRIFFITH,	:	Case Number: 2000-BLA-629
Claimant,	:	
	:	
v.	:	
	:	
CLINCHFIELD COAL COMPANY,	:	
Respondent,	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,	:	
Party-in-Interest.	:	

Bobby S. Belcher, Jr., Esquire
For the Claimant

Timothy W. Gresham, Esquire
For the Respondent

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER - REJECTION OF CLAIM

Statement of the Case

This proceeding involves a request for modification of a claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §§ 901 et seq. ("the Act"), and the regulations promulgated thereunder.[1] Since this claim was filed after March 31, 1980, Part 718 applies. §718.2 Because the

[1]All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Claimant's Exhibits are denoted "C-"; Director's Exhibits,

Claimant Miner was last employed in the coal industry in Virginia, the law of the United States Court of Appeals for the Fourth Circuit controls (D-1, 2, 3). *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989)(*en banc*).

Procedural History

The initial claim was filed by the Claimant, James F. Griffith, on April 27, 1995 (D-1). The Department of Labor issued an initial determination of eligibility on July 2, 1996 (D-24). Following Clinchfield Coal Company's request for and the conduct of a formal hearing, Judge Morgan denied benefits on October 27, 1997, because the evidence established neither the existence of pneumoconiosis nor any other respiratory or pulmonary condition related to coal mine employment (D-26, 33, 35, 42, 53, 55). Claimant appealed (D-56). On March 31, 1999, the Benefits Review Board affirmed (D-60).

On August 23, 1999, Claimant submitted additional evidence and filed a request for modification (D-61). The District Director denied the request on November 17, 1999. Claimant submitted additional evidence, and the District Director issued a Proposed Decision and Order Denying Request for Modification on March 21, 2000 (D-65, 69). The Claimant appealed and requested a formal hearing on March 28, 2000 (D-70). This tribunal scheduled this case for hearing on December 19, 2000. Claimant did not appear at the hearing and the parties agreed to submit the case on the record (Tr. 4-6). An order for this case to be decided on the record was issued on January 3, 2001. Pursuant to that order, the previously submitted evidence was admitted to the formal record and written argument was ordered to be filed no later than January 31, 2001. Accordingly, the exhibits admitted into the evidentiary record were Director's Exhibits one (1) through seventy-two (72), Claimant's Exhibits one (1) through seven (7), and Employer's Exhibits one (1) through thirteen (13). By written letter dated December 29, 2000, Clinchfield Coal Company, Employer, waived its contest to the responsible operator issue. This tribunal's findings and conclusions which follow are based upon an analysis of the entire record, reviewed *de novo*, together with applicable statutes, regulations, and case law, in relation to those issues which remain in substantial dispute.

Issues

1. Whether the Claimant has proved the existence of a mistake in a determination of fact, or a change of conditions since March 31, 1999?
2. Whether the Claimant has established the existence of coal workers' pneumoconiosis?
3. Whether the Claimant's pneumoconiosis, if proved, was caused by his coal mine employment?
4. Whether the Claimant's total disability is due to coal workers' pneumoconiosis?

"D-"; Employer's Exhibits, "E-"; and citations to the hearing transcript are denoted "Tr."

Findings of Fact, Conclusions of Law, and Discussion

Benefits under the Act are awardable to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. For the purpose of the Act, pneumoconiosis, commonly known as black lung, means a chronic dust disease of the lung, and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. A disease arising out of coal mine employment includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. Section 718.201. In order to obtain federal black lung benefits, a claimant must prove by a preponderance of the evidence that: "(1) he has pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) he has a totally disabling respiratory or pulmonary condition; and (4) pneumoconiosis is a contributing cause to his total respiratory disability." *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 529, 21 BLR 2-323 (4th Cir. 1998); *see Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195, 19 BLR 2-304 (4th Cir. 1995); 20 CFR §§718.201-.204 (1999); *Gee v. W.G. Moore & Sons*, 9 BLR 1-4 (1986).

Background, Coal Mine Employment, and Smoking History

Claimant was born on November 20, 1942, and completed ten years of formal education (D-1). In the original claim, the Employer and Claimant stipulated to at least twenty-five years of coal mine employment (D-53 at 27-28). Judge Morgan found that the record reflects at least twenty-five years of coal mine employment, and accepted the stipulation (D-55). In this case, the Claimant and Employer stipulated to at least twenty years of coal mine employment (D-71). This tribunal has reviewed the Claimant's employment history and finds that Judge Morgan's finding that the Claimant was employed as a coal miner for at least twenty-five years is supported by the record and involves no mistake in fact. (D-2-8). Claimant ceased working for the Employer during a layoff on August 30, 1994, and drew unemployment for a few months, then worked for Upper Mill Mining for about eighteen days (D-4, 53 at 17). He left the coal mining industry on February 10, 1995 for health reasons, and has not worked in the coal mining industry since (D-1, 53 at 17). Claimant's wife, Elsie, whom he married on July 24, 1965, and to whom he is presently married, is the Claimant's only dependent for purposes of augmentation of benefits under the Act (D-10, 71).

The Claimant's last job in the coal mines was section foreman (D-2, 53 at 14.) The record reflects that he had been a section foreman since 1972; prior to that time, he was a continuous miner operator (D-2). In a work history form filed in conjunction with his previous claim, the Claimant described the duties of his job as section foreman as, "fire boss, clean area with scoop, operate equipment to fill in for workers, maintain and repair equipment, rock dust, etc." This work required him to stand from eight to ten hours per day and lift forty to one hundred pounds twenty times per day. (D-8). At the hearing before Judge Morgan, Claimant described his job as section foreman as follows, "enter the face, I make all gas checks, run my center lines and go from the miner to the roof bolter. Most of the time I stay with the miner." (D-53 at 14-15). He kept the section clean and filled in for jobs when they were short on men (D-53 at 15). The Claimant considered the work hard physically, and worked ten hour shifts, five to six days per week (D-53 at 15-16). The Claimant's main job was to supervise the hourly employees, and he stated that if he did

classified work, it could be subject to a grievance (D-53 at 22).

Claimant inconsistently reported his smoking history to various persons involved in this claim, and, accordingly, his testimony on this issue is not credible. On February 10, 1995, Claimant underwent an exercise study administered by Dr. Robinette at Johnston Memorial Hospital at which he reported a smoking history of twenty-five years at a rate of one and one-half packs of cigarettes per day, having quit two years before, which would be 1993 (D-47, 48). The Claimant informed Dr. Forehand, on May 8, 1996, that he smoked one pack of cigarettes per day from 1976 to 1990 (D-15). On September 11, 1996, Claimant informed Dr. Sargent that he smoked one-half pack of cigarettes per day for fifteen years, and quit seven years prior to the examination (D-31). At the hearing for his original claim, the Claimant testified that he was a former smoker, but could not recall when he began smoking. However, he believed that he started smoking while in his twenties, and stated that he quit smoking on April 5, 1990 (seven years prior to the hearing). Claimant did not recall telling anyone that he still smoked in 1992 or 1993 or later. (D-53 at 23-26). On June 25, 1999, Claimant underwent pulmonary function testing pursuant to his examination by Dr. Robinette. The pulmonary function testing report indicated that the Claimant smoked cigarettes for twenty-five years, quitting four years prior to the examination, in 1995 (D-63). On October 23, 2000, Claimant informed Dr. Hippensteel that could not remember how much he smoked, but knew that he quit in 1993, and may have begun smoking while in his late thirties (E-8). Based on the Claimant's various accounts, his smoking history was anywhere from seven and one-half pack years to thirty-seven and one-half pack years. This tribunal finds that Claimant's smoking history was at least twenty-two years in length. Not only did Claimant twice report a twenty-five year smoking history to his treating physician, Dr. Robinette, but, if the Claimant began smoking in his twenties and quit either in 1993 or 1995, as his testimony to several physicians bears out, the Claimant's smoking history would range from a low of twenty-two years (1971-1993) to a high of thirty-three years (1962-1995).

Modification: Change in Conditions or Mistake of Fact

Claimant's request for modification is governed by§725.310, which provides that any party may request modification of an award or denial of benefits if such request is filed within one year of the denial alleging a change in conditions or mistake in a determination of fact. Where mistake of fact forms the grounds for the modification request, new evidence is not a prerequisite, and a mistake of fact may be corrected whether demonstrated by new evidence, cumulative evidence, or further reflection on evidence initially submitted. *Kovac v. BCNR Mining Corporation*, 16 BLR 1071 (1992), *modifying* 14 BLR 1-156 (1990). If no specific mistake is alleged, but the ultimate determination of entitlement is challenged, the entire record must be examined for a mistake in a determination of fact. *See Jessee v. Director, OWCP*, 5 F.3d 723, 18 BLR 2-26 (4th Cir. 1993). The administrative law judge, as trier-of-fact, has the authority, and the duty, to review the record evidence *de novo* and is bound to consider the entirety of the evidentiary record, and not merely the newly submitted evidence, in making a mistake in a determination of fact finding upon modification. *See Nataloni v. Director, OWCP*, 17 BLR 1-82, 1-84 (1993); *Kovac v. BCNR Mining Corp.*, 14 BLR 1-156 (1990), *modified on recon.*, 16 BLR 1-71 (1992); *see also Jessee*, 5 F.3d at 725, 18 BLR at 2-28; *see generally, O'Keeffe v. Aerojet-General Shipyards, Inc.*,

404 U.S. 254, 257 (1971).

Change in conditions as an alternate ground for modification focuses on whether there has been a worsening of the miner's pulmonary disease to the point that it is now totally disabling. In determining whether a change in conditions has occurred, an Administrative Law Judge must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision." *See Nataloni v. Director. OWCP*, 17 BLR 1-82, 1-84 (1993); *Kingery v. Hunt Branch Coal Co.*, 19 BLR 1-6 (1994; *Napier v. Director, OWCP*, 17 BLR 1-111 (1993).

Evidence Submitted Since Denial of the Previous Claim

X-ray Evidence[2]

Exhibit No.	X-ray Date	Reading Date	Physician/ Qualifications	Interpretation
D-67	3/25/97	12/10/99	Castle B	0/1, q/p; tb; calcified granulomata
D-67	3/25/97	12/14/99	Hippensteel B	0/1, q/p; tb; multiple scattered small calcified granulomas mostly in apices
D-66	3/25/97	12/9/98	Dahhan B	0/0
D-61	6/25/99	6/25/99	Robinette B	2/2; q/t; axillary coalescence; lungs expanded with evidence of interstitial pulmonary fibrosis
D-68	6/25/99	11/17/99	McLeod B/R	1/2; r/t; old fracture of rib; left granulomas
E-1	6/25/99	3/22/00	Wheeler B/R	0/0; tb, fractured ribs; small ill defined mixed irregular and nodular infiltrate or fibrosis apices and subapical portion upper lobes with few small calcified granulomata and minimal apical pleural thickening compatible with TB unknown activity, probably healed; emphysema; probable small granulomata at level of left cardiophrenic angle

[2] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0"signifies that the film was read completely negative for pneumoconiosis.

E-2	6/25/99	3/22/00	Scott B/R	0/0; emphysema; fractured ribs; linear fibrosis apices compatible with healed tb; hyperinflation of the lungs; small calcified granuloma right apex
E-3	6/25/99	7/5/00	Fino B	0/0; granulomatous changes are seen in both upper zones
C-4	4/26/00	4/30/00	Robinette B	1/2; q/t; coalescence; emphysema, fractured ribs; ?early category A mass LUL
E-5	4/26/00	10/20/00	Scott B/R	0/0; emphysema, fractured ribs; few small calcified granulomata and linear scars apices compatible with healed tb
E-6	4/26/00	10/21/00	Wheeler B/R	0/0; bullae?; fractured ribs; tb; subtle fibrosis or small infiltrate right apex and few small scars mixed with tiny calcified granulomata in apices and lateral periphery upper lobes with minimal left apical pleural thickening compatible with tb unknown activity, probably healed; emphysema with areas of decreased and distorted lung markings and possible small bleb at level of lower left hilum; no evidence of silicosis or CWP
E-7	4/26/00	11/9/00	Fino B	0/0; bilateral upper lobe granulomatous changes
E-8	10/23/00	10/23/00	Hippensteel B	0/1; q/p; emphysema; scattered calcified granulomas in both apices along with linear scars in both lungs not suggestive of CWP; this suggests a combination of granulomatous inflamation, linear scars from old inflictions and emphysema
E-9	10/23/00	11/13/00	Wheeler B/R	0/0; bullae; emphysema; fractured ribs; tb; COPD with small bullous blebs and areas of decreased and distorted lung markings; minimal fibrosis or infiltrate in both apices and subapical portion LUL compatible with tb unknown activity, probably healed with minimal left apical pleural thickening; tiny scar or calcified granuloma in lateral periphery RUL or pleura

E-10	10/23/00	11/10/00	Scott B/R	0/0; emphysema?; fractured ribs; probable minimal fibrosis apical and calcified granulomata compatible with healed Tb, activity cannot be excluded ; hyperinflation of the lungs: deep breath versus emphysema
E-11	10/23/00	11/22/00	Fino B	granulomatous changes in upper zones

Pulmonary Function Studies[3]

Exhibit	**Date**	**Physician**	**Ht/age**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying**
D-63[4]	6/25/99	Robinette	67"/56	1.20 1.40	2.47 2.91		48.58% 47.28%	Yes Yes
E-8	10/23/00	Hippensteel	67"/57	1.25 1.33	2.62 2.85	41	48.00% 47.00%	Yes Yes

[3] The second set of listed values relates to post bronchodilator test results.

[4] Dr. John A, Michos, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed the June 25, 1999 pulmonary function study and found the vents unacceptable and noted that the report did not include tracings. He noted that the computerized values for each volume-time maneuver were not enclosed. He stated that he was unable to ascertain the validity and reproducibility of the test. (D-64).

Dr. Kirk E. Hippensteel, board-certified in internal and critical care medicine and the subspecialty of pulmonary diseases, reviewed the June 25, 1999 pulmonary function study on August 3, 2000. He noted that a marked hyperintensive response was noted during the performance of the test, but that it was not clear from the report whether such a hyperintensive response interfered with performance of the test. He also noted that the values of individual efforts were not reported on the spirometry. Dr. Hippensteel explained that the Claimant's best efforts pre and post bronchodilator had peak expiratory flows that were suboptimal, especially post-bronchodilator, indicative that the results underestimated his true function even with partial reversibility of function in asthmatic range post bronchodilator. He further noted that only one diffusion result was listed which showed a suboptimal inhalation of gas for the test, and accordingly made for an abnormal DLCO, but a normal value when corrected for volume inhaled for the test. He concluded that it was not possible to determine how much of an underestimate of the Claimant's lung function that the values represented, but that since there were specific measurements indicative of less than optimal effort shown, the study could be stated, with a reasonable degree of medical certainty, to underestimate the Claimant's true function. Accordingly, Dr. Hippensteel invalidated the study specifically under federal black lung regulations.

Arterial Blood Gas Studies

Exhibit	Date	Physician	pO_2	pCO_2	Qualifying
E-8	10/23/00	Hippensteel	99.1	35.9	No
E-8	10/24/00	Hippensteel	78.9	32.6	No (exercise)

CT Scan Evidence

Exhibit	CT Scan Date	Reading Date	Physician/ Qualifications	Interpretation
D-66	1/5/98	9/16/98	Scott B/R	Linear scarring with calcifications both apices. Minimal apical pleural thickening. Few small calcified granulomata right upper lung. Changes compatible with healed TB. 2 x 1.5 mass right lower lobe near hemidiaphragm, probably small lipoma or fat herniation through hemidiaphragm. No evidence of silicosis/CWP.
D-66	1/5/98	9/11/98	Wheeler B/R	Minimal linear and irregular fibrosis with several small calcified granulmata in apices and upper lobes compatible with healed [ ] with some linear scars in upper lobes and apices extend to pleura. Emphysema with hyperinflation lungs, increased AP diameter chest and areas of decreased and distorted lung markings mainly in upper lobes. Probable extrapleural fat or herniated intraabdominal fat through posterior right hemidiaphragm. No evidence of silicosis or CWP.

D-66	1/5/98	8/7/98	Fino B	No changes consistent with occupational pneumoconiosis. There are granulomatous changes seen in the upper lung zones.

Medical Opinion Evidence

Dr. Emory H. Robinette, board-certified in internal medicine and the subspecialty of pulmonary diseases, prepared a medical opinion dated February 26, 1998 in the form of a letter addressed to Claimant's attorney.[5] (D-58). Dr. Robinette explained that he had treated the Claimant "for his pulmonary disease over the past several years," and, that, "Mr. Griffith has underlying black lung disease with axillary coalescence and radiographic changes similar to that seen in progressive massive fibrosis or large opacity pneumoconiosis." Dr. Robinette stated that a CT scan was performed at Johnston Memorial Hospital in January 1998 which demonstrated multiple nodules in the range of approximately one centimeter in size. He also stated that the CT scan revealed diffuse thickening throughout the interstitium and linear stranding through the upper lung zones with pleural scarring. Dr. Robinette stated, "This was felt to be consistent with diffuse nodular interstitial lung disease and compatible with underlying silicosis without evidence of a definite mass effect." He opined that the Claimant had progressive airflow obstruction as evidenced by the Claimant's April 1997 spirometry. Dr. Robinette concluded that the Claimant suffered from disabling pulmonary disease as a consequence of his underlying black lung diagnosis, and that his condition was chronic and irreversible.

Dr. Robinette examined the Claimant on June 25, 1999 (D-61, 63). The examination included an x-ray and pulmonary function testing. The pulmonary function testing report indicates that the Claimant smoked cigarettes for twenty-five years, quitting four years prior to the examination (D-63). Dr. Robinette interpreted the x-ray as positive for pneumoconiosis, category 2/2, q/t. He opined that the pulmonary function testing, which revealed decreased FEV1 and FVC, reduced diffusion capacity, elevated total lung capacity, and severe obstructive lung disease with response to bronchodilator therapy, was consistent with underlying coal workers' pneumoconiosis with a progressive airflow obstruction. Dr. Robinette noted that when compared to testing performed in 1995, the Claimant's FEV1 and FVC have decreased consistently with progressive airflow obstruction. Based on the pulmonary function study, Dr. Robinette advised clinical

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[5] This tribunal notes that Director's Exhibit 58 was submitted to Judge Morgan under cover letter dated June 1, 1998. Because Judge Morgan's Decision and Order Denying Benefits was dated October 27, 1997, the Claimant appealed his decision to the Benefits Review Board on November 20, 1997, and the Benefits Review Board issued its Decision and Order affirming Judge Morgan's denial of benefits on March 31, 1999, Dr. Robinette's February 1998 report was untimely submitted to Judge Morgan as the case was properly before the Benefits Review Board on June 1, 1998. Moreover, Claimant's submission was considered premature as a request for modification, as it was Dr. Robinette's June 25, 1999 report that Claimant submitted in support of his request for modification. Accordingly, because Dr. Robinette's February 1998 report has yet to be considered in this claim, it is properly considered by this tribunal in the current request for modification.

correlation. Dr. Robinette opined that the Claimant had evidence of coal workers' pneumoconiosis with evidence of axillary coalescence and distortion of his primary parenchyma with progressive airflow obstruction. He concluded that the Claimant was disabled from working and suffered from "disabling pulmonary disease which is chronic and irreversible."

The record contains six office notes from Dr. Robinette pursuant to Dr. Robinette's treatment of the Claimant's "underlying black lung disease"every four months. On September 22, 1998 the Claimant returned to Dr. Robinette's office for "follow-up of his underlying black lung disease." (C-1). Dr. Robinette noted that the Claimant continued to have chronic cough, congestion, shortness of breath and dyspnea. Examination of his chest revealed diminished breath sounds with bilateral expiratory wheezes and prolongation of the expiratory phase. He asked the Claimant to continue his current medications which included Theo-Dur, Proventil, and Atrovent. The Claimant returned to Dr. Robinette's office on January 22, 1999 for follow-up of his underlying black lung disease with areas of pleural thickening and fibrotic reaction. (C-2). His symptoms of chronic cough, shortness of breach and dyspnea continued. Dr. Robinette noted that "there has been no hemoptysis." He also noted that the Claimant had recurrent episodes of tracheobronchitis requiring antibiotics. Chest on auscultation noted diminished breath sounds with bilateral expiratory wheezes present and prolongation of the expiratory phase. The Claimant's medications remained unchanged, with the addition of Keflex for suppression of the Claimant's tracheobronchitis.

The Claimant returned to Dr. Robinette's office on May 28, 1999. (C-3). Dr. Robinette noted the Claimant's "long history of chronic cough, congestion, shortness of breath, and dyspnea related to his primary disease and report[ed] increasing shortness of breath which has been responsive partially to his medication." Dr. Robinette noted that the Claimant denied hemoptysis. Claimant's chest revealed diminished breath sounds with wheezes heard in both lung bases. Dr. Robinette noted his request for repeat pulmonary function studies and chest x-ray to document the Claimant's current respiratory reserve. On December 28, 1999, Dr. Robinette noted that the Claimant returned to his office for follow-up of his underlying black lung disease with "clinical progressive massive fibrosis and axillary coalescence." (C-5). He noted that pulmonary function studies performed in the summer of 1999 "clearly documented internal deterioration of his lung function." The Claimant's chest on auscultation revealed diminished breath sounds with poor air movement. Dr. Robinette noted moderate prolongation of the expiratory phase. The Claimant's current medications included Combivent, Theo-24, and antibiotics on a "p.r.n. basis."

Claimant returned to Dr. Robinette's office on April 26, 2000 with "evidence of fibrosis and axillary coalescence." (C-6). Dr. Robinette stated, "The Black Lung Department recently denied his black lung claim and apparently are discounting the severity of his pulmonary disease or the radiographic abnormality which have been described on prior evaluations." Chest on auscultation revealed diminished breath sounds with prolongation of the expiratory phase and wheezes and rhonchi. Dr. Robinette noted that he asked the Claimant to continue all "base medications," that the Claimant's oxygen saturation was stable, and that he requested a follow up chest x-ray for comparison to prior films to exclude progression of the radiographic abnormalities. Dr. Robinette examined the Claimant on September 7, 2000. (C-7). He noted that the Claimant's symptoms of cough, congestion, and dyspnea persisted, and that the Claimant was treated for

an early pneumonia during the summer. Chest on auscultation revealed diminished breath sounds with prolongation of the expiratory phase and wheezes. Dr. Robinette noted that the chest x-ray taken on April 26, 2000 was interpreted as being consistent with pneumoconiosis with a profusion abnormality of 1/2, predominant q/t opacities in all six lung zones. He noted evidence of emphysema, axillary coalescence and possible early category A mass in the left upper lobe. He noted that "These radiographic abnormalities appeared to have slowly progressed over the past several years." Dr. Robinette concluded that based on past spirometry and x-ray abnormalities, the Claimant had a disabling pulmonary disease and was unable to work as an underground coal miner.

Dr. Kirk Hippensteel, board-certified in internal and critical care medicine and the subspecialty of pulmonary diseases, examined the Claimant on October 23, 2000 and prepared a report based on that examination and his review of additional medical evidence as outlined in pages four through eleven of his report dated November 6, 2000. (E-8). Dr. Hippensteel recorded the Claimant's pertinent medical and social histories and conducted a physical examination which included a chest x-ray, pulmonary function and arterial blood gas testing, and a resting electrocardiogram. The Claimant reported a thirty-one year history of coal mine employment and described his duties as a section foreman, which required him to walk three hundred feet across sections in high seam coal and lift up to forty pounds several times per day. Claimant reported that he did not have a regular morning cough and rarely got respiratory infections. Claimant denied a history of tuberculosis and said that he had a tuberculosis skin test three years prior to the examination which Dr. Robinette thought was negative. Claimant could not remember how much he smoked, but knew that he quit in 1993 and may have began smoking while in his late thirties. Claimant reported that he chews tobacco and had done so since before he started smoking. Claimant reported that he used one bag of tobacco about every three days.

Dr. Hippensteel interpreted the chest x-ray as non suggestive of coal workers' pneumoconiosis, but suggestive of a combination of granulomatous inflammation and linear scars from old infections and emphysema. He noted that the Claimant's spirometry indicated severe airflow obstruction with very mild improvement post bronchodilator, and that his MVV was severely reduced with tidal volumes varying greater than twenty-five percent. The Claimant's lung volumes showed air trapping with no restriction. His diffusion was mildly reduced, but normal for the volume inhaled. Claimant's arterial blood gases showed normal oxygenation at rest and at the end of exercise. Claimant had nonspecific electrocardiographic changes during exercise with exercise stopped because of dizziness and dyspnea with no chest pain.

Based on the data obtained from his examination of the Claimant, Dr. Hippensteel concluded that the Claimant did not have sufficient evidence to support a diagnosis of coal workers' pneumoconiosis. In support of his conclusion, Dr. Hippensteel explained that Claimant had severe airflow obstruction without restriction on pulmonary function tests that could relate to smoking. He further explained that the Claimant's chest x-ray was not compatible with complicated coal workers' pneumoconiosis, noting that partially calcified lesions in upper lobes are inconsistent with causation diagnostic of simple pneumoconiosis, and that, while there was a minor amount of rounded opacities that could be related to granulomatous inflammation, they could represent a minimal increase in markings insufficient in degree to be categorized as from pneumoconiosis. He further explained that the changes on the Claimant's x-ray were not

suggestive of coalescing small opacities, but were more typical of granulomatous disease than pneumoconiosis.

Dr. Hippensteel, in a detailed analysis of the medical records provided to him in this case, opined that Dr. Robinette was wrong in his assessment of the Claimant as suffering from coal workers' pneumoconiosis and complicated coal workers' pneumoconiosis. Dr. Hippensteel reiterated his findings and concluded that the Claimant did not have coal workers' pneumoconiosis or impairment related thereto, "when looking at the combination of radiographic, physiologic, and examination findings as well as a continued history of bronchitis episodes and treatment with bronchodilators in this man. The findings in this man are indicative of progressive impairment referable to asthma and contributed to by his cigarette smoking history and chronic bronchitis." Dr. Hippensteel concluded that the Claimant's impairment prevented him from returning to his regular job in the coal mines. He opined that even if the Claimant was stipulated to have coal workers' pneumoconiosis based on his minor x-ray abnormalities, the abnormalities he had were not enough to cause the impairment he had and would not disable him from is last coal mine employment.

Dr. Hippensteel was deposed on December 6, 2000. (E-13). He reviewed his credentials and examination procedure, reiterating the various histories reported to him by the Claimant (E-13 at 4-8). Dr. Hippensteel reiterated his findings upon examination (E-13 at 8-11, 15-19, 28-30). Focusing on Claimant's chest x-ray taken during his examination, Dr. Hippensteel explained that he observed calcified granulomas in both apices along with linear scars which he opined were not suggestive of coal workers' pneumoconiosis, but were suggestive of "some kind of granulomatous disease in the past." (E-13 at 11). He continued to explain that granulomas are inflammations which occur as a reaction to specific infectious and noninfectious insults, and are separate and different from the inflammations caused by coal dust or silica exposure. Dr. Hippensteel explained that there are other granulomatous diseases than tuberculosis, which Claimant was said not to have. (E-13 at 11-12). In comparing the x-ray taken during his examination of the Claimant with x-rays from March 25, 1997 and April 26, 2000, Dr. Hippensteel found them to have similar readings, noting that the April 26, 2000 film showed slightly more irregular and rounded noncalcified markings than the other films (E-13 at 12-13). Dr. Hippensteel explained that the CT scan interpretations provided by other physicians generally showed findings compatible with granulomatous disease and no evidence of coal workers' pneumoconiosis (E-13 at 14-15). Dr. Hippensteel explained in great detail that the Claimant's pulmonary function test, significant for severe air flow obstruction with mild improvement postbronchodilator and unassociated with a diffusion impairment, gas exchange impairment or restriction, was inconsistent with lung impairment related to coal workers' pneumoconiosis. Comparing this study with the Claimant's past pulmonary function studies, Dr. Hippensteel noted a pattern of reversibility, which showed a change after the Claimant left the mines and one that is consistent with some cigarette smoking. He noted that reversibility is not attributable to coal workers' pneumoconiosis. He also noted that the respiratory pattern was not associated with a change or deterioration in x-ray findings. (E-13 at 19-20).

Dr. Hippensteel agreed that coal dust exposure can cause obstructive impairments, noting that if coal dust exposure had caused the degree of obstruction exhibited by the Claimant, one would expect to see an additional restrictive impairment and progression of x-ray abnormalities (E-13 at 21). However,

Dr. Hippensteel agreed that x-ray evidence "is not the last word in determining whether or not an individual does suffer from coal workers' pneumoconiosis," though, he stated, "It is a significant word." (E-13 at 25). Dr. Hippensteel also stated that impairments caused by smoking or coal dust exposure can progress after the exposure ceases (E-13 at 26). Dr. Hippensteel reiterated the conclusions from his previous report, explaining in detail that the Claimant's disabling respiratory impairment was contributed to by the Claimant's cigarette smoking, a possible component of asthma as evidenced by past pulmonary function tests, and possibly was contributed to by Claimant's granulomatous disease and previous history consistent with chronic bronchitis (E-13 at 22-23).

Evidence Submitted with the Previous Claim–Reviewed Here for a Mistake in a Determination of Fact and Utilized Thereafter as a Basis for Comparison to Determine a Change in Conditions

Having reviewed the evidence contained in the evidentiary record before Judge Morgan in conjunction with his Decision and Order of October 27, 1997, this tribunal finds that Judge Morgan's decision provides a reliable and complete inventory of the evidence submitted with the previous claim (D-55 at 5-12). Based on review of that evidence, this tribunal found no mistake in a determination of fact.

In his decision dated October 27, 1997, Judge Morgan outlined the x-ray and CT scan evidence, noting that of thirty-two x-ray interpretations of nine x-ray films taken from April 1992 through March 1997, only three readings were positive for pneumoconiosis. (D-55 at 6, 7, 14). Judge Morgan found that all of the more highly qualified B-readers who were also radiologists read the x-rays as negative for pneumoconiosis and noted tuberculosis. Three B-readers, Drs. Gaziano, Sargent and Fino, also noted granulomatous scarring consistent with tuberculosis as well as emphysema. Judge Morgan pointed out that the most recent x-ray, dated March 25, 1997, was read as "consistent with silicosis" by Dr. Mullens, whose credentials were not of record, and as showing massive fibrosis with emphysema by Dr. Robinette, a B-reader (D-52). However, Judge Morgan also noted that the x-ray was re-read by dually qualified board-certified radiologists and B-readers, Drs. Wheeler and Scott as 0/1, with tuberculosis and emphysema, and was read negative by Dr. Fino, a B-reader (D-51). Judge Morgan also noted that the March 1995 CT-scan was interpreted by three readers, two of whom were board-certified radiologists, as negative for pneumoconiosis and was not interpreted as positive by any reader of record (D-34, 50, 56 at 14).

Dr. Robinette was the only physician who diagnosed complicated pneumoconiosis. In an office note dated March 17, 1997, Dr. Robinette stated, "X-rays have documented evidence of a category A mass in the right upper lobe with area[s] of progressive massive fibrosis and evidence of black lung disease." Dr. Robinette opined in that note that the Claimant had "evidence of complicated pneumoconiosis with a category A mass, right upper lobe with evidence of obstructive and possible restrictive lung disease." (D-52). Because Dr. Robinette did not discuss the possibility of old or active granulomatous disease, which was noted and was of some concern to the majority of the other readers, and because Drs. Pendergrass, Wheeler, Scott, and Fino had the opportunity to observe and comment upon a series of x-rays spanning five years and did not identify the category A mass or any other form of pneumoconiosis,

Judge Morgan found Dr. Robinette's opinion was outweighed by the majority of physicians (D-55 at 14). Finding the opinions of the most qualified physicians and the majority of B-readers to be in accord that the Claimant did not have radiographic evidence of pneumoconiosis, Dr. Morgan concluded that the radiographic evidence did not establish the existence of the disease.

There was no biopsy evidence before Judge Morgan or this tribunal, and Judge Morgan found that the medical opinions of Drs. Robinette and Forehand which found pneumoconiosis to exist were outweighed by the better reasoned opinions of Drs. Sargent, Fino, and Castle, which were based on more extensive objective evidence. (D-15, 31, 46, 47, 50, 51, 52). In particular, Judge Morgan found that Dr. Forehand's opinion was entitled to less weight because he did not have an accurate smoking history for the Claimant and did not have the benefit of the later, normal arterial blood gas studies in forming his opinion (D-55 at 15). Judge Morgan did not find Dr. Robinette's report to be a well-reasoned opinion diagnosing pneumoconiosis because his report "did not discuss any data, nor asthma, nor the possibility of tuberculosis (which was noted by all other physicians), nor emphysema, nor smoking history or its possible contribution to pulmonary disability, nor any specific x-ray showing massive fibrosis. He does not mention any past medical reports or testing, including the CT scan, with the exception of his treatment if the Claimant on 02/19/97 for 'acute bronchitis exacerbation of his lung disease' with Keflex." (D-55 at 16). After finding that none of the diagnoses of other possible respiratory afflictions were proven to be related to the Claimant's coal mine employment, Judge Morgan found that the Claimant did not establish the existence of pneumoconiosis by reasoned medical opinions or by any other means. No factual error is apparent in Judge Morgan's analysis.

Judge Morgan determined that Claimant had established total disability based on qualifying pulmonary function studies and the consensus of all physicians of record who considered the issue of disability (Drs. Forehand, Sargent, Fino, and Castle) (D-13,15, 31,46, 50,51, 55 at 17). Judge Morgan did not find that the Claimant had established that his total disability was due to pneumoconiosis. Dr. Forehand was the only physician who linked the Claimant's totally disabling respiratory condition to coal dust exposure (D-15).[6] However, Judge Morgan accorded his opinion less weight than the opinion of Dr. Sargent, also an examining physician, which was in accord with the opinions of the reviewing pulmonary specialists, Drs. Fino and Castle. Judge Morgan again noted that Dr. Forehand utilized an inaccurate smoking history, only reviewed a single x-ray and pulmonary function study, and made an unsubstantiated diagnosis of chronic bronchitis (D-55 at 18). Judge Morgan credited the opinions of Drs. Sargent, Fino, and Castle, who all specifically stated why the Claimant's respiratory impairment was due to cigarette smoking and asthma and cited objective medical evidence in support of their conclusions (D-55 at 18). No factual error is apparent in that analysis.

No mistake in a determination of fact is apparent in Judge Morgan's conclusions that the evidence did not establish the existence of pneumoconiosis or that the Claimant's totally disabling respiratory

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[6] Dr. Robinette never stated an opinion that the Claimant was disabled. Instead, he referred to a disability determination made by Dr. Forehand. (D-52).

impairment was due to pneumoconiosis; the x-ray evidence before him was overwhelmingly negative for pneumoconiosis, and the only two physicians' opinions that found pneumoconiosis, those of Drs. Forehand and Robinette, were not credible, and, explicitly or by implication, there was no other credible evidence of the existence of pneumoconiosis in the record before him (D-55). Judge Morgan's determinations were affirmed by the Benefits Review Board (D-60).

Change in Conditions

Existence of Pneumoconiosis

Section 718.202(a) prescribes four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§ 718.304, 718.305, 718.306; or (4) the finding by a physician of pneumoconiosis as defined in § 718.201 which is based upon objective evidence and a reasoned medical opinion. The record contains no evidence of a biopsy, and the presumptions under §§ 718.305 and 718.306 are inapposite, because the claim was filed after 1981, and because the miner is living. The presumption under §718.304 is appropriately considered in this claim because the record contains evidence of complicated pneumoconiosis.

The existence of pneumoconiosis requires consideration of "all relevant evidence" under §718.202(a), as specified in the Act. Thus, if a record contains both relevant x-ray interpretations and biopsy reports, the Act would prohibit a determination based on x-ray alone, or without evaluation of physicians' opinions that the miner suffered from "legal" pneumoconiosis. *See Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 BLR 2-104 (3d Cir. 1997); *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162, 2000 WL 524798 (4th Cir. 2000).

Employer submitted three re-readings of the March 25, 1997 film. Drs. Castle and Hippensteel, both B-readers, read the film as 0/1 and noted tuberculosis and calcified granulomata (D-67). Dr. Dahhan, also a B-reader, read the film as completely negative. The newly submitted June 25, 1999 film was interpreted positive by both Dr. Robinette, a B-reader, who also noted expansion of the lungs and pulmonary fibrosis, and Dr. McLeod, a dually qualified board-certified radiologist and B-reader (D-61, 68). Dr. McLeod also noted the presence of granulomas and a fractured rib (D-68). To the contrary, Drs. Wheeler and Scott, both dually qualified board-certified radiologists and B-readers, and Dr. Fino, a B-reader, interpreted the film as negative for pneumoconiosis (E-1, 2, 3). All three physicians noted the presence of granulomatous changes/granulomas, and Drs. Wheeler and Scott noted emphysema, fractured ribs, and tuberculosis. Claimant also submitted an x-ray dated April 26, 2000, and interpreted by Dr. Robinette as positive for pneumoconiosis, emphysema, and fractured ribs (C-4). Dr. Robinette also noted the possibility of an early category A mass; but, he did not make a finding of complicated pneumoconiosis by checking the appropriate box on the ILO form. Drs. Wheeler, Scott and Fino reviewed the April 26, 2000 film, and all read it consistently with their individual interpretations of the June 25, 1999 film (E-5, 6, 7). Employer submitted four readings of the October 23, 2000 film taken in conjunction with Dr.

Hippensteel's examination of the Claimant. Dr. Hippensteel interpreted the film as negative for pneumoconiosis, 0/1, and positive for emphysema, calcified granulomas with linear scars (E-8). Drs. Wheeler, Scott, and Fino again provided interpretations consistent with their prior individual findings (E-10, 11). This pattern of x-ray interpretations corroborates the x-ray readings of the prior claim. Here, four films were interpreted sixteen times, and the majority of physicians were in accord that the films were negative for pneumoconiosis, but positive for granulomatous diseases, like tuberculosis, and emphysema. Moreover, the only dually qualified board-certified radiologist and B-reader to interpret an x-ray as positive for pneumoconiosis, Dr. McLeod, did not have the benefit of reviewing a series of films, but did note the presence of granulomas. As in the previous claim, Dr. Robinette did not note the presence of granulomas/granulomatous disease. Accordingly, because this newly submitted radiographic evidence does not differ qualitatively from the evidence in the previous claim, Claimant has not established the existence of pneumoconiosis by a preponderance of the x-ray evidence.[7]

There was no evidence of biopsy; however, there was some evidence of complicated pneumoconiosis. Under §718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if the miner is suffering from complicated pneumoconiosis. Complicated pneumoconiosis is established by x-rays classified as Category A, B, or C, by an autopsy or biopsy, which yields evidence of massive lesions in the lung, or by equivalent diagnostic means. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the administrative law judge must consider and weigh all relevant evidence. *Melnick v Consolidation Coal Co.*, 16 BLR 1-31 (1991).

In the previous claim, Judge Morgan found that Dr. Robinette's March 17, 1997 diagnosis of "evidence of complicated pneumoconiosis with category A mass, right upper lobe with evidence of obstructive possible restrictive lung disease" stood alone among the numerous x-ray readings by multiple readers, many of whom were dually qualified board-certified radiologists and B-readers, and physicians' opinions (D-55 at 13, fn. 7). In the current request for modification, in his February 26, 1998 report, Dr. Robinette again diagnosed the Claimant with "radiographic changes similar to that seen in progressive massive fibrosis." (D-58). Not only did Dr. Robinette fail to definitively diagnose progressive massive fibrosis by qualifying his diagnosis with "similar," but he neglected to refer to any specific x-ray films or interpretations.[8] Dr. Robinette's treatment notes do not refer to the Claimant's alleged progressive massive fibrosis again until December 28, 1999, though the record indicates that the Claimant returned to Dr. Robinette's office at least four times prior to December 1999, but after his February 1998 examination.

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[7] This tribunal also finds that the CT scan evidence supports this tribunal's conclusion that the radiographic evidence does not establish the existence of pneumoconiosis. The January 5, 1998 CT scan was interpreted by Drs. Wheeler, Scott, and Fino as completely negative for pneumoconiosis, but positive for granulomatous changes (D-66). The record contains no interpretations to the contrary.

[8] In that same report, Dr. Robinette also referred to a CT scan performed in January 1998 which demonstrated "multiple nodules in the range of approximately 1 cm. in size" and "several smaller nodules." No CT scan report accompanied the February 1998 report, and while Dr. Robinette opined that the CT scan findings were consistent with diffuse nodular interstitial lung disease and compatible with underlying silicosis "without evidence of a definite mass effect," he did not rely on the CT scan for his diagnosis of progressive massive fibrosis. (D-58).

In the December 1999 office note, Dr. Robinette only noted that the Claimant returned to his office for follow-up of his "underlying black lung disease with clinical progressive massive fibrosis and axillary coalescence." (C-5). Dr. Robinette neither referred to specific x-ray or CT scan evidence, nor did he explain his sudden return to a diagnosis of progressive massive fibrosis as opposed to his usual limited reference to the Claimant's "underlying black lung disease" that appears in his other treatment notes of the Claimant. (See C-1, 2, 3, 6, 7). Dr. Robinette only referred to one x-ray, taken April 26, 2000, that mentioned the finding of a category A mass (C-4, 7). However, Dr. Robinette was the only reader to interpret the film as positive for pneumoconiosis, and, he only noted that there was evidence of a "possible early category A mass," and neglected to fill in the appropriate box for a diagnosis of complicated pneumoconiosis. (C-4, 7). Because Dr. Robinette's opinion is equivocal and internally inconsistent, and because his opinion is unsupported by either specific objective medical evidence or corroborating medical opinions, this tribunal finds that Dr. Robinette's opinion does not support a finding of complicated pneumoconiosis. *See Island Creek Coal Co. v. Holdman*, 202 F.3d 873, 22 BLR 2-25, 2000 WL 65029 (6th Cir. 2000); *Church v. Eastern Associated Coal* Corp., 20 BLR 1-8 (1996); Hopton *v. U.S. Steel Corp.*, 7 BLR 1-12 (1984).

Two physicians provided medical opinions as part of the evidence on modification of this claim. At the outset, this tribunal notes that both physicians are equally qualified as board-certified in internal medicine and the subspecialty of pulmonary diseases. Dr. Robinette provided two medical reports and six office notes for Claimant's regular quadra- monthly office visits (D-61, C-1, 2, 3, 5, 6, 7). As Dr. Robinette was the Claimant's treating physician for a relevant period of time, greater weight may be accorded to his opinion. §718.104(d). However, in *Collins v. J & L Steel*, 21 BLR 1-182 (1999), the Board held that it was error for the administrative law judge to give greater weight to a treating physician's opinion without addressing its "flaws." And, in *Tedesco v. Director, OWCP*, 18 BLR 1-103 (1994), the Board specifically stated that an administrative law judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician, rather this is one factor which may be taken into consideration." Other factors to be considered include whether the report is well-reasoned and well-documented.

Only one of Robinette's six office notes rises to the level of reasoned medical opinion for many of the reasons identified by Judge Morgan in the previous claim. While the office notes from September 1998, January and May 1999, and April 2000 refer to the Claimant's "underlying black lung disease," Dr. Robinette never discussed in these notes how he reached that diagnosis, which objective data he relied upon, the Claimant's smoking history or its possible contribution to the Claimant's respiratory disability, or any specific x-rays or objective medical testing in support of a pneumoconiosis diagnosis (C-1, 2, 3, 6). And, while Dr. Robinette's office note from December 28, 1999 explains that pulmonary function testing performed in the summer of 1999 "[c]learly documented interval deterioration of his [Claimant's] lung function," Dr. Robinette provided no evidence that he utilized this pulmonary function testing in formulating his opinion regarding the Claimant's pneumoconiosis, nor did he explain whether he considered or how he ruled out other possible causes for the Claimant's deteriorating lung function (C-5). Dr. Robinette's September 7, 2000 office note is the only note in which he identified the objective evidence that he relied upon in support of his diagnosis of pneumoconiosis. In that note, Dr. Robinette specifically stated at the

end of the note that it was "pertinent to note" that the Claimant's chest x-ray from April 26, 2000 was interpreted as being consistent with pneumoconiosis (C-7).

Neither of Dr. Robinette's reports substantiate a finding of pneumoconiosis because they are not in accord with the objective medical evidence of the case and were refuted and outweighed by the well-reasoned medical opinion of Dr. Hippensteel. In his February 26, 1998 report, Dr. Robinette concluded that the Claimant suffered a "disabling pulmonary disease as a consequence of his underlying black lung diagnosis. His condition is chronic and irreversible." (D-58). His conclusion was expressly based on a January 1998 CT scan interpretation[9] allegedly demonstrating multiple nodules which he found consistent with diffuse nodular interstitial lung disease compatible with underlying silicosis, and spirometry performed in April 1997 evidencing progressive airflow obstruction. As noted by Dr. Hippensteel in his consultative report for this claim, Dr. Robinette's conclusion is inconsistent with the medical evidence of record and with his own treatment of the Claimant. First, three physicians, two of whom are board-certified radiologists, all interpreted the abnormalities found in the January 1998 CT scan as incompatible with changes associated with pneumoconiosis, but compatible with granulomatous disease, noting the presence of small calcified granulomata in the upper lobes (D-66, E-13 at 14-15).[10] Second, though Dr. Robinette characterized the Claimant's obstructive airways disease as irreversible, he treated Claimant with bronchodilator medications, to which Claimant was responsive, used to produce reversibility in lung disease patients (See C-1, 2, 3, 5, 6, 7; D-58, 61; E-8). Dr. Hippensteel reviewed the two pulmonary function tests admitted to the record in the previous claim, performed in May and September 1996, and noted that both showed improvement after administration of bronchodilators, and that the improvement in the May 1996 test was consistent with an asthmatic response (D-13, 31, E-8).[11] Dr. Hippensteel also noted that the two pulmonary function studies admitted in this claim, performed in June 1999 and October 2000, also exhibited improvement after bronchodilator administration, with the Claimant's FEV_1 and FVC increasing seventeen and eighteen percent, respectively, in the 1999 test, and six and nine percent, respectively, in the 2000 test (D-63, E-8).[12] Dr. Hippensteel explained during his deposition that Claimant's improvement upon bronchodilator administration indicates a pattern of reversibility (E-13 at 19).

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[9] The report of this CT scan interpretation is not contained in the evidentiary record.

[10] Dr. Hippensteel explained, during his December 6, 2000 deposition, that a CT scan is "a special kind of x-ray that looks at slices, like a loaf of bread, slices through the chest, and so it actually takes away some of the obstructing or obscuring parts of the rib cage and other structures on a chest x-ray." (E-13 at 14). Accordingly, because CT scans are a form of x-ray, it may be presumed that board certified radiologists are proficient in their interpretation and provide the most reliable readings as opposed to non-radiologists.

[11] Dr. Hippensteel testified that an improvement of twelve percent or greater justifies the diagnosis of asthma (E-13 at 26).

[12] Despite his finding that the June 1999 test was invalid and underestimated the Claimant's true lung function, Dr. Hippensteel noted that the Claimant's post-bronchodilator improvement was consistent with an asthmatic response (E-8).

Dr. Robinette's June 25, 1999 report was based on a complete examination of the Claimant. (D-61, 63). This report confirms an internal inconsistency in Dr. Robinette's opinion regarding the reversibility of the Claimant's obstructive impairment. Dr. Robinette twice noted in the report that the Claimant exhibited a response to bronchodilator therapy, indicating some degree of reversibility, yet ended the report by stating that the Claimant's disabling pulmonary disease "is chronic and irreversible." While Dr. Robinette reasoned to a conclusion that the Claimant had pneumoconiosis as evidenced by the June 25, 1999 x-ray and pulmonary function study, his opinion is entitled to little weight. Although Dr. Robinette's spirometry report indicates that the Claimant's smoking history spanned twenty-five years, Dr. Robinette never referred to the Claimant's smoking history in his report or analysis, nor did he opine as to its possible contribution to the Claimant's pulmonary disability. Moreover, the radiographic and CT scan evidence overwhelmingly indicate that the small nodules/masses in the Claimant's lungs are unrelated to coal dust inhalation, and instead are evidence of a past granulomatous disease that caused the formation of calcified granulomas. While Claimant informed Dr. Hippensteel that Dr. Robinette tested him for tuberculosis via skin test, which he believed was negative, the record does not indicate whether Dr. Robinette considered the presence of any possible disease processes associated with the formation of granulomas (E-8). Accordingly, because Dr. Robinette's opinions are internally inconsistent, fail to identify and account for the Claimant's smoking history (which he consistently reported to Dr. Robinette as twenty-five years in length), do not indicate that he reviewed evidence produced outside of this own office, and reach conclusions contrary to the medical evidence and other reasoned opinion of record, his opinion, even as the Claimant's treating physician, is entitled to little weight. *See Mabe v. Bishop Coal Co.*, 9 BLR 1-67 (1986)*;Tedesco v. Director, OWCP*, 18 BLR 1-103 (1994)**;** *Cranor v. Peabody Coal Co.*, 22 BLR 1-1 (1999) (*en banc on recon.*) (The Board concluded that it was proper for the administrative law judge to give less weight to the report of a physician because his opinion was based upon a CT scan which was not in the record and he did not have the benefit of reviewing the two most recent qualifying pulmonary function studies.)

Alternatively, this tribunal accords greater weight to the well-reasoned and documented opinion of Dr. Hippensteel. Dr. Hippensteel had both the opportunity to examine the Claimant and review extensive medical evidence dating back to 1992 (See E-8 at 4-11). Dr. Hippensteel accounted for both the Claimant's smoking and work histories, and ruled out the Claimant's coal mine employment as the cause of his obstructive pulmonary impairment, noting that the radiographic evidence suggested the presence of scarring due to a past granulomatous disease rather than pneumoconiosis; the pulmonary function studies indicated the presence of obstruction entirely without restrictive component, dramatic reversibility consistent with an asthmatic component, and lung volumes exhibiting air trapping; and the Claimant's continued history of bronchitis episodes (E-8, 13). Because Dr. Hippensteel based his opinion on extensive medical data, specifically identified the studies and other objective evidence he relied upon in forming his opinions, accounted for Claimant's coal mine employment and smoking history, and because the conclusion he reached is consistent with the underlying objective evidence of record, his opinion is accorded substantial weight in support of this tribunal's finding that the medical opinion evidence does not establish the existence of pneumoconiosis in this case. *Church v. Eastern Associated Coal Corp.*, 20 BLR 1-8 (1996). Accordingly, because the Claimant has failed to establish the existence of pneumoconiosis either by x-ray or medical opinion evidence, there is no proof of a change in conditions

in that regard.

Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose out of his coal mine employment. Pursuant to §718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established at least twenty-two years of coal mine employment. Thus, had he established the existence of pneumoconiosis, he would have also been entitled to invoke the rebuttable presumption that his pneumoconiosis arose from his coal mine employment under the provisions of §718.203(b). But, because he has not established the existence of pneumoconiosis, the issue is moot.

Total Disability Due to Coal Workers' Pneumoconiosis

To prove that a claimant is totally disabled by pneumoconiosis he must establish that he has a totally disabling respiratory or pulmonary condition, 20 CFR §718.204(c), and show that his pneumoconiosis is a contributing cause to this total disability. *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38, 14 BLR 2-68, 2-76 (4th Cir. 1990); *Scott v. Mason Coal Co.*, 14 BLR 1-37, 1-41, 1-42 (1990). It is not enough for the miner to establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments. Pursuant to §718.204(c), the ALJ must weigh all relevant evidence, like and unlike, with the burden on the claimant to establish total respiratory disability by a preponderance of the evidence. *See Budash v. Bethlehem Mines Corp*., 16 BLR 1-27 (1991)(*en banc*); *Fields v. Island Creek Coal Co.*, 10 BLR 19 (1987); *Rafferty v. Jones & Laughlin Steel Corp*., 9 BLR 1-231 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986). Then pursuant to §718.204(b), in the Fourth Circuit, the claimant must prove by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his totally disabling respiratory impairment. *See Hobbs v. Clinchfield Coal Co. [Hobbs II]*, 45 F.3d 819, 19 BLR 2-86 (4th Cir. 1995); *Robinson*. So long as total pulmonary disability is properly established, the miner's other disabling conditions are irrelevant. *See Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 19 BLR 2-1 (4th Cir. 1994); *Tussey v. Island Creek Coal Co.*, 982 F.2d 1036 (6th Cir. 1993).

Dr. Robinette was the only physician who opined that the Claimant's total disability was due to pneumoconiosis. However, because the preponderance of the evidence indicates that the Claimant does not have pneumoconiosis, and because Dr. Robinette's opinions were found by this tribunal to be inconsistent with the objective evidence of record and outweighed by the opinion of Dr. Hippensteel, who attributed the Claimant's disabling pulmonary impairment to his documented cigarette smoking history, possible component of asthma, granulomatous disease and previous history consistent with chronic bronchitis, this tribunal finds that the Claimant has not established that he is totally disabled due to pneumoconiosis, and has not established a change in conditions with regard to this element. (E-13 at 22-23)

Conclusion

The new evidence is generally consistent with evidence and medical opinions previously submitted by the parties and considered by other adjudicators, and is not indicative of a mistake in a determination of fact. Dr. Robinette continues to stand alone as the only physician to opine that the Claimant has pneumoconiosis based on radiographic evidence and pulmonary function testing. Though Dr. Robinette has been aprised of the Claimant's smoking history, he ignores its possible relevance in this case. Dr. Hippensteel's opinion corroborated the previous findings of Drs. Fino, Castle and Sargent and accounted for the extensive medical evidence suggesting that the Claimant's lungs are scarred by a prior granulomatous disease of unknown origin and that the Claimant has a reversible obstructive pulmonary impairment attributable to his smoking history and possible asthma and bronchitis, but not due to pneumoconiosis. Claimant has failed to establish a change of conditions, and review of the evidence of record and the conclusions based upon it disclose no mistake in a determination of fact. Consequently, Claimant has established no basis that would require or allow his requested modification, or an award of black lung benefits.

ORDER

Claimant James F. Griffith's request for modification and claim for black lung benefits are denied.

A
EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.